MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
15410
15143
File No. 4344
Registered No.

1. PLACE OF DEATH
County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. Lady Hospital St. Ward)

2. FULL NAME Catherine B Blackwell
(a) Residence. No. 1808 - S. 10th St., 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
abt	60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Mr. Blackwell
(Address) 1808 S 10th St

15. FILED APR 21 1928 Mar C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 19 1928

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1928, to 4-19, 1928, that I last saw her alive on 4-14, 1928 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* WAS AS FOLLOWS:
1. Chronic Nephritis Interstitial
2. Ulcers Duodenum + Gastric
Chronic
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Cerebral Thrombosis
Apoplexy
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1808 to 10
DID AN OPERATION PRECEDE DEATH? DATE OF?
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? Physical findings
(Signed) [illegible], M. D.
4/19, 1928 (Address) 3604 S Broadway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Olive — DATE OF BURIAL 4-21 1928
20. UNDERTAKER Southern — ADDRESS 7315 Brady

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Schmidt
3824 S. Bdwy